

COMMUNITY ACCESS PROGRAM

PROGRAM APPLICATION GUIDANCE

BACKGROUND

In 1998, 44.5 million people in the United States did not have health insurance. Of these, 24.6 million were employed -- 18.7 million worked full time and 5.9 million worked part time.

The uninsured and underinsured often have complex medical needs, remain outside organized systems of care, and have insufficient resources to obtain care. They may defer care or not receive needed services, and they are about half as likely to receive a routine check-up as insured adults. The uninsured and underinsured also rely heavily on expensive emergency rooms, and because they lack a routine source of care, they often do not receive needed follow-up services.

Many of the uninsured and underinsured rely on the nation's institutions, systems, and individual health professionals that provide a significant volume of health care services without regard for ability to pay. In many communities, these providers are struggling to care for the increasing numbers of uninsured and underinsured individuals. They face many challenges such as an uneven distribution of the burden of uncompensated care, the fragmentation of services for the uninsured, insufficient numbers of certain types of providers, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

While integration among these providers is critical to serve the uninsured and underinsured with greater efficiency and to improve quality of care, many of these providers are so pressured by basic caregiving tasks, they need assistance to coordinate their efforts with other providers and to develop integrated community-based systems of care.

The Department of Health and Human Services (DHHS) is committed to assisting communities and their safety net providers in developing integrated health care delivery systems that serve the uninsured and underinsured with greater efficiency and improved quality care. In FY 2000, DHHS will provide \$25 million in funding for up to 20 communities to further their development of integrated delivery systems for the uninsured.

This announcement provides information and application guidance on this new DHHS initiative – the Community Access Program (CAP). The \$25 million in available funding has been appropriated under the FY 2000 HHS Appropriations Act. The initiative will be managed by the Office of the Administrator of the Health Resources and Services Administration. Grants will vary in size, based on the scope of the project and the size of the service area. With a typical grant not to exceed \$1 million, approximately 20 awards are anticipated. We welcome applications from rural and tribal organizations.

During the first year of funding for this program, HRSA will support infrastructure development in communities that have already begun to reorganize and integrate their health care delivery systems. FY 2000 funding is not intended to support those communities that have not yet begun the planning and development of necessary organizational structure.

Up to 100 communities may ultimately be funded as part of this national program targeted by the Administration to spend \$1 billion over five years. FY 2000 funded communities may be eligible for available FY 2001 funding (assuming continued appropriations) to support further infrastructure development and filling service gaps. In addition, using the experiences of the FY 2000 funded communities as potential models for adaptation, FY 2001 funding is anticipated for support of new communities for planning and system development. Thus, communities that have not yet begun the planning and development of necessary organizational structure should have an opportunity to apply in FY 2001.

Over the years that the program is funded, funds are anticipated to be available to fill service gaps within coordinated systems of care.

This program shares some of the same goals of the W.K. Kellogg Foundation's Community Voices Program and the Robert Wood Johnson Foundation's Communities in Charge Program. Thus, CAP will take into account the experiences of these foundations as well as other programs that promote the integration of services to the uninsured and underinsured.

THE COMMUNITY ACCESS PROGRAM

Program Purpose: The purpose of this program is to assist communities and consortia of health care providers to develop the infrastructure necessary to fully develop or strengthen integrated health systems of care that coordinate health services for the uninsured.

Program Goal: The coordination of services through the CAP grant will allow the uninsured and underinsured to receive efficient and higher quality care and gain entry into a comprehensive system of care. The system will be characterized by effective collaboration, information sharing, and clinical and financial coordination among all levels of care in the community network. The system will be committed to continuous performance improvement, implementation of best practices, staff development, and real-time feedback of outcomes of care. Care management (e.g., case, disease) will be applied across the continuum for those with chronic illnesses, high-risk individuals, and high utilizers. The system will also strive to provide universal access to the target population, and to improve the health status of the community population.

This vision requires a re-thinking of the relationships, priorities, and desired outcomes for local or regional care delivery. It means adopting the philosophy that care for the ill and injured occurs within the context of a comprehensive system design of population health improvement.

The community being served should be actively involved in the system design. Broad understanding, two-way learning between providers and community, and participation in priority setting and governance by the community are essential components of this vision. This will reduce out migration for services in rural areas and assure sustainability of the system.

PROGRAM DESCRIPTION

In implementing a system of coordinated care for the uninsured and underinsured in a community, we are seeking to fund a variety of program models in communities that have an established track record for building partnerships and that have completed the basic planning necessary to implement a system. The successful applicant will design a program that builds upon its current capacities and strengths; brings the major players in the political and health delivery systems to the table; uses the federal funds available to plan a transition to an expanded and innovative approach that will ultimately be competitive within its own market; and, in any event, will sustain the delivery of services and funding after these federal grants no longer exist. The successful applicant will work with its county board, city council, state legislature, and state health programs to assure the coordination and efficient use of all available resources to achieve program goals.

There is no one successful model that we are trying to replicate. Rather, there are several models that already exist that each community may draw from in creating a program to address its needs.

In surveying innovative community approaches to the provision of safety net services, we have found communities that have:

- coordinated the provision of care through public hospitals, public health departments, and community health centers;
- combined the development of managed care networks for the indigent funded through local tax increases and the redirection of funds towards the care network and away from the support of tertiary care at public hospitals;
- redistributed caseload to private providers because of the forced closure of public hospitals;
- linked hospital and clinic services through state of the art data systems and are able to create seamless transitions between Medicaid, uninsured, and insured status for low income populations;
- linked behavioral and acute care service provision; and
- created networks to allocate uncompensated ambulatory care loads among physicians.

We are looking for applicants with clear goals, an operational plan for meeting those goals, a history of commitment to serving indigent populations, and enough of a track record to indicate a fair chance at being successful. Innovative proposals for sustaining the service delivery component of projects could include creative use of local or state taxing authorities, use of tobacco settlement funds, and creative partnerships with the

provider and business communities. Applications will be judged from the perspective of whether the financing proposed is realistic—given state and community resources—and appropriate to the project proposed.

Funded projects will contain several common elements:

Community Need: Communities funded through this program will have high or increasing rates of uninsured and underinsured and will have identified specific organizational needs within existing delivery systems. A “community” for the purpose of this program may be based on geography or a population group (e.g., the homeless) as defined by the people in the community.

Collaboration Among Safety Net Providers: The proposed system should build upon current investments in communities for serving these populations and include the safety net providers who have traditionally provided services without regard to the ability to pay. The coalition should be built upon formal arrangements among the partners that define the extent of the commitment and involvement in policy development and decision-making of each partner.

Comprehensive Services: The proposed system will include all partners necessary to assure access to a full range of services, including mental health and substance abuse treatment. It is anticipated that the health services programs (prevention, primary, and specialty) provided by Federally-supported programs that are present in the community will be part of this coalition of providers.

Coordination with Public Insurance Programs: The proposed system will demonstrate coordination with state programs (e.g., memorandum of agreements) to ensure that eligible beneficiaries are enrolled in public insurance programs (e.g., S-CHIP, Medicaid).

Community Involvement: There is strong community support for these efforts that provide a broad foundation of assistance to the provider community undertaking this project. Management and governance structures are in place that assure accountability to funders and define the community role in setting policy. The community involvement in the development, implementation, and governance of the project will be evident. This should include the leadership within the appropriate legislative and executive bodies, providers identified above, health plans and payers, and community leaders.

Sustainability: A plan for long-term sustainability is designed and has community consensus. There is evidence that the program is capable of leveraging other sources of funds and integrating current funding sources in a way to assure long-term sustainability of the project.

ELIGIBLE APPLICANTS

To encourage the development of various types of system integration models, this program seeks a variety of applicants representing all types of communities. Applicants who receive funding may be large health care systems or small organizations. Applications are encouraged from large urban areas, small rural communities, and tribal organizations.

Applications may be submitted by public, private, and non-profit entities who demonstrate a commitment to and experience with providing a continuum of care to uninsured individuals. Each applicant must represent a community-wide coalition that is committed to the project and includes safety net providers (where they exist) who have traditionally provided care to the community's uninsured and underinsured regardless of ability to pay. The community-wide coalition must consist of partners from all levels of care (i.e., primary, secondary, tertiary) and partners who represent a range of services (e.g., mental health and substance abuse treatment, maternal and child health care, oral health, HIV/AIDS).

Examples of eligible applicants who may apply on behalf of the community-wide coalition include but are not limited to:

- A consortium or network of providers (e.g., public and charitable hospitals; community, migrant, homeless, public housing, and school-based health centers; rural health clinics; free health clinics; teaching hospitals and health professions education schools)
- Local government agencies (e.g., local public health departments with service delivery components)
- Tribal governments
- Managed care plans or other payers with a commitment to the target population
- Agencies of State governments, multi-state health systems, or special interest groups may submit applications on behalf of multiple communities if they demonstrate the ability to coordinate community health care delivery systems and bring resources to the community.

Competing applications for the same patient population will not be considered for funding; therefore, applicants from the same community should collaborate.

FUNDING CRITERIA

Review criteria that will be used to evaluate applications include:

- Evidence that the target population has a high or increasing rate of uninsurance
- Evidence of progress towards integration prior to application for funding
- Accountable management and budget plan with supporting data systems
- Appropriateness and quality of clinical services to be provided
- Evidence of established partnerships among a broad-based community consortium
- Commitments from local government agencies, public and private health care providers, community leaders
- Demonstration of existing and sustainable public and private funding sources
- Commitment to self evaluation and participation in a national evaluation

PROGRAM EXPECTATIONS

Funding through this initiative may be used to support a variety of projects that would improve access to all levels of care for the uninsured and underinsured. While each community should design a program that best addresses the needs of the uninsured and underinsured, and the providers in their community, funding is intended to encourage safety net providers to develop coordinated care systems for the community's uninsured and underinsured.

Examples of activities that could be supported with this funding include:

- Offering a comprehensive delivery system for the uninsured and underinsured through a network of safety net providers. [Single registration, eligibility systems]
- Integrating preventive, mental health, substance abuse, HIV/AIDS, and maternal and child health services within the system. [Block grant funded services, other DHHS programs, state and local programs]
- Developing a shared information system among the community's safety net providers. [Tracking, case management, medical records, financial records]
- Developing and incorporating shared clinical protocols, quality improvement systems, utilization management systems, and error prevention systems.
- Sharing core management functions. [Finance, purchasing, appointment systems]
- Coordinating and strengthening priority services to specific targeted patient groups.
- Developing affordable pharmaceutical services.

USE OF GRANT FUNDS

Funding provided through this program may NOT be used to substitute for or duplicate funds currently supporting similar activities. Grant funds may support costs such as:

- Project staff salaries
- Consultant support
- Management information systems (e.g., hardware and software)
- Project-related travel
- Other direct expenses necessary for the integration of administrative, clinical, information system, or financial functions
- Program evaluation activities

With appropriate justification on why funds are needed to support the following costs, up to 15 percent of grant funds may be used for:

- Alteration or renovation of facilities
- Primary care site development
- Service expansions or direct patient care

Grant funds may NOT be used for:

- Construction
- Reserve requirements for state insurance licensure

EXPECTED RESULTS

The integration and coordination of services among a community's safety net providers are expected to result in:

- A system of care that provides coordinated coverage to the target population.
- Increased access to primary care resulting in a reduction in hospital admissions for ambulatory sensitive conditions among the uninsured and underinsured.
- Elimination of unnecessary, duplicate functions in service delivery and administrative functions, resulting in savings to reinvest in the system.
- Increased numbers of low-income uninsured people with access to a full range of health services.

APPLICATION FORMAT AND INSTRUCTIONS

Each application for the Community Access Program must include the following sections in order to be considered eligible:

1. Cover Letter: A one-page cover letter should identify the community for which the application is being submitted, the lead organization with complete contact information, and the amount of grant funding being requested.
2. Table of Contents: A one-page table of contents should outline each section of the application and all appendices.
3. Project Abstract (2 page limit): A project abstract should briefly describe each of the following:
 - Applicant community
 - Target population
 - Current delivery system for the uninsured
 - Goal of the proposed project
 - Proposed intervention that the grant would support
 - Partners collaborating in the project
 - Projected results
4. Community Needs Assessment (4 page limit): This section should describe the current needs of the community. The community needs assessment should identify the service area for the project, describe the target population, and assess the current delivery system for the target population. The needs assessment should serve as the basis for the project plan and should specifically include the following:
 - Description of the current delivery system – Include an assessment of existing resources and programs for the uninsured and underinsured, the types of providers who deliver the most care for this population, barriers in the current delivery system, and gaps in service delivery. If available, provide information on the number or proportion of uninsured or underinsured in each provider's caseload and/or the share of the total community-wide uninsured care that it provides.
 - Target population – Include data that describe the number of uninsured and underinsured. To the extent possible, also describe the income status and cultural diversity of this population. The most current data available should be cited. Also, include an analysis of why the target population is uninsured or underinsured. If the target population for the project is a subset of the

community's uninsured population, explain why this subpopulation is being given priority.

If available, append a legible map that denotes the location of the service area and targeted population.

- Projection of potential changes in insurance coverage – Include a discussion of any projected increases or declines in private or public insurance coverage. Describe any community efforts designed to expand coverage.
- Assessment of most urgent needs – Include an assessment of the most urgent needs of the project's target population (e.g., emergency care, pharmacy, coordination of care, access to specialty services, immunizations, dental services).

5. Evidence of Progress Towards Developing an Integrated System of Care for the Target Population (4 page limit): This section should describe the accomplishments made to date by the collaborators towards the development and implementation of an integrated health system to serve the target population. Specifically, the application should describe each of the following:

- History and progress of collaboration – List the active partners who are part of the integrated system and describe any system integration efforts that have already taken place.
- Formal arrangements already established within the community – Describe any formal relationships or structures that bind the collaborators. [Append memoranda of agreement, state or local founding arrangements, tribal resolutions, or other official documents.]
- Capacity to assume grant – Include a brief history of the lead organization's experience in managing a coordinated system of care. Also, describe the lead organization's capacity for assuming direct fiduciary responsibility over the administration and management of the project.

6. Statement of Project and Budget (12 page limit): Based on the community needs assessment, this section should describe the proposed project. Specifically, the application should describe each of the following:

- Statement of project – In narrative format, describe the specific program objectives and the action steps planned to achieve each objective. Also, describe how the program objectives relate to the community needs assessment.

- Project management matrix – Include a matrix that lists the objectives, action steps to accomplish each objective, when and by whom results are expected to be achieved, and how they will be measured. The matrix should be organized as follows:

(NOTE: Applicants may have as many objectives and actions steps needed for their proposed project and are not limited to 2 objectives with 3 action steps each.)

Objective 1:			
	Timetable for Each Action Step	Responsible Organization or Person	Anticipated Results
Action Step 1:			
Action Step 2:			
Action Step 3:			
Objective 2:			
	Timetable for Each Action Step	Responsible Organization or Person	Anticipated Results
Action Step 1:			
Action Step 2:			
Action Step 3:			

If one of the project's Action Steps includes the development of a management information system (MIS), please append a supplemental description of the existing MIS and the proposed enhancements (*additional 2 pages allowed*). This supplemental information on MIS development will be reviewed separately by a technical review panel.

- Organizational structure and accountability – This should describe the management, accounting, and governance structure of the collaboration. Include any plans for a formal affiliation or describe existing affiliation agreements. Provide resumes for key staff and/or position descriptions.

- Budget plan – The budget plan for the project must provide the following:
 - An itemized budget that is coordinated with the project management plan. The budget should account for the total grant funds requested and should include any other funds that would be used for the project. In addition to the itemized budget, provide a brief narrative for each line item on the budget.
 - Description of how grant funds would be managed by the collaboration partners, including accountability for funds.
 - Explanation of why the project cannot be implemented with the coalition's existing resources.
 - Assurance that grant funds will not be used to supplant other funding that is currently supporting services to the target population.
7. Scope and Quality of Services (8 page limit): This section should describe the scope of the services proposed in this project and the quality of services that would be provided to the target population. Specifically, the application should describe each of the following:
- Collaboration among a range of providers in the community – Demonstrate that the collaboration involves all appropriate health care providers necessary to assure access to the range of services planned to be delivered to the target population. Provide criteria for the inclusion or exclusion of providers in the project's network.
 - System coordination – Describe how the project's services will be coordinated. Also, describe the information and patient tracking systems that will be used and any plans for joint system development across providers. Discuss the impact of this coordination on the target population.
 - Clinical quality – Describe the methods, objectives, and instruments for measuring and evaluating clinical quality.
 - Cultural and linguistic competency – Describe how culturally and linguistically appropriate services will be ensured.
 - Links to social services – Describe links with social services and enabling services in the community.

8. Community Partnerships and Sustainability (6 page limit): This section should describe the community's vision for and plan to develop an integrated, sustainable delivery system. Specifically, the application should describe each of the following:
- Community involvement – Describe which elements of the community were involved in the design of the project and how they will continue to be involved in its implementation.
 - Commitment to the community and the population – Describe the historical commitment of the collaborators to the community's uninsured. Provide evidence that the proposed project would build on current investments for serving the target population.
 - Funding support and sustainability – Describe the current funding sources that support care for the uninsured in the community; anticipated support of state and local governments, foundations and local philanthropy, or others; and plans for long-term sustainability of the project. Also, describe plans for continued financing of the activities of the collaboration beyond the one-year term of this grant.
 - Reinvestment in the community – Describe how projected savings from project efficiencies would be used and how they would result in improved care for the target population.
9. Evaluation Plan (2 page limit): This section should describe the applicant's plan for self evaluation and the capacity of the applicant to participate in a national program evaluation:
- Self evaluation plan – Describe the applicant's plan for self-evaluation and a monitoring process that would be used to track and measure progress towards the project's goals and objectives. Self evaluation plans should be developed for two time frames: short term (i.e., one year) and long term (e.g., 2, 3, 4+ years). Also, briefly describe any applied health services evaluations that have already been conducted by the collaboration and are comparable to that described in the self-evaluation plan.
 - National program evaluation – Indicate the applicant's commitment to participate in a national program evaluation and willingness to collect data required by the Secretary. Describe the capacity and limitations of the applicant's data system. At a minimum, applicants should be able to report on the number of uninsured people in the community, the number of uninsured who receive care through the project, changes in these two measures over time, and changes in the volume of care (e.g., service increase).

APPLICATION REVIEW CRITERIA

Each of the applications that has passed an eligibility and conformance review by the Federal staff will be assigned to members of an Objective Review Committee (ORC) for review. Members of the ORC will use the following evaluation criteria in their review of applications:

1. Community Needs Assessment (5 Points):

- 1.1 Extent to which the applicant has provided evidence of significant unmet needs for the target population.
- 1.2 Extent to which the target population has a high or increasing rate of uninsurance or underinsurance.
- 1.3 Extent to which the income status and cultural diversity of the target population indicates high need.
- 1.4 Extent to which the applicant documents projected declines in public or private insurance coverage.

2. Evidence of Progress towards Developing Integrated Systems for the Uninsured and Underinsured (20 Points):

- 2.1 Evidence of collaboration partners' prior commitment to providing care to the target population.
- 2.2 Evidence of results or accomplishments achieved from system integration efforts.
- 2.3 Evidence of formal relationships among collaborators for project purposes.
- 2.4 Capacity of the applicant to receive and administer funds on behalf of the coalition and evidence that it is authorized to act on behalf of the project partners.

3. Statement of Project and Budget (20 Points):

- 3.1 Extent to which the proposed project effectively addresses the needs of the target population as described in the needs assessment.
- 3.2 Extent to which the proposed project is innovative.

- 3.3 Extent to which the proposed project describes clear goals, objectives, planned activities, timeframes, and projected results that relate to and support the goals and objectives.
- 3.4 Extent to which the proposed project has an appropriate organizational structure and staff to carry out the plan.
- 3.5 Extent to which the itemized budget (with both existing funding sources and requested funding) is reasonable for the activities proposed and supports the project management plan.
- 3.6 Extent to which the proposed project describes who has authority for making financial decisions and how funds will be managed and accounted for.

4. Scope and Quality of Services (25 Points):

- 4.1 Extent to which the proposed project includes an appropriate range of services for the target population and adequate health care providers to carry out the project.
- 4.2 Extent to which the proposed project would coordinate services among project providers, manage patient referrals, and coordinate patient information.
- 4.3 Extent to which the proposed project would integrate substance abuse and mental health services into its system.
- 4.4 Extent to which the proposed project describes methods and objectives that would be used for measuring clinical quality.
- 4.5 Extent to which the proposed project describes methods and objectives that would be used for ensuring culturally and linguistically appropriate services.
- 4.6 Extent to which the proposed project describes appropriate linkages to social services and enabling services in the community

5. Community Partnerships and Sustainability (20 Points):

- 5.1 Extent to which the proposed project includes community participation in the design, management, and implementation of the project.
- 5.2 Extent to which the proposed project includes a management structure to ensure ongoing community involvement.

- 5.3 Extent to which the proposed project builds on current programs in the community that serve the uninsured and underinsured.
- 5.4 Extent to which the proposed project involves those providers who have traditionally served the uninsured in their community.
- 5.5 Extent to which the ongoing governance structure involves the relevant participants in the community.
- 5.6 Extent to which the proposed project demonstrates a firm commitment of State, local, and /or private funding and /or in-kind contributions dedicated to sustaining services for the target population.
- 5.7 Extent to which the proposed project can demonstrate matching funding from private resources.

6. Evaluation and Quality Improvement Plan (10 Points):

- 6.1 Extent to which the proposed project has a self-evaluation plan that would track progress towards goals and objectives identified in the management plan.
- 6.2 Extent to which the proposed project describes its information technology capability (e.g., capacity to report the number of uninsured people in the community, the number of uninsured who receive care, and changes in health status disparities over time) and any plans for enhancement.
- 6.3 Extent to which the proposed project commits to participate in a national program evaluation.

APPLICATION SUBMISSION AND REVIEW PROCESS

Contact for Application Kit: To receive a complete application kit, contact the HRSA Grants Application Center at **1-877-HRSA-123**.

Pre-Application Workshops: There will be a series of six pre-application workshops conducted across the country. For more information on these workshops, call 301-443-0536.

Application Contents: Components of the application, all of which must be submitted, should be assembled in the following order:

- Standard Form PHS 5161
- Cover Letter
- Table of Contents
- Application Sections as Outlined Above
- Appendices

Standard Forms are included with the Application Kit. The Community Access Program application must be no more than 42 pages. Please do not send additional information beyond appendices requested in the application instructions.

Applications and appendices must:

- Be typed single-spaced in standard size black type (not to exceed 15 characters per inch) on 8 ½ x 11 paper that can be photocopied. Each page must be numbered consecutively;
- Have 1 inch border margins; and
- Only be typed on one side of each page.

State Point of Contact: This program has been determined to be subject to provisions of Executive Order 12372, as implemented by 45 CFR Part 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. The Form PHS 5161 contains a listing of States that have set up a review system and will provide a State point of contact (SPOC) in the State for the review.

Applicants (other than federally-recognized Indian tribal governments) should contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the appropriate deadline dates. HRSA does not guarantee that it will accommodate or

explain its responses to State process recommendations received after the due date. (See “intergovernmental Review of Federal Programs” Executive Order 12372, and 45 CFR Part 100, for a description of the review process and requirements.)

Address for Submission: Applicants must submit an original (with signature) and two copies of the application to:

HRSA Grants Application Center
1815 N. Fort Meyer Drive
Suite 300
Arlington, VA 22209

Application Due Date: Applications are due on **June 1, 2000**. Applications will be considered as meeting the deadline if they are either (1) received on or before the deadline date or (2) postmarked on or before the deadline date and received in time for orderly processing. Applications that do not meet the deadline will be considered late and will be returned to the applicant.

Application Review Process: Applications will undergo an eligibility and conformance review by Federal staff. An Objective Review Committee will review applications that are deemed eligible. The HRSA will issue awards no later than **September 30, 2000**.

Contact for Questions on the Application: Questions regarding this application guidance should be addressed by one of the following HRSA Field Offices closest to you:

NAME	TITLE	PHONE #	HRSA FIELD OFFICE	STATES AND US TERRITORIES COVERED
Ken Brown	Assistant Field Director	617-565-1420	Boston	Connecticut, Maine, Massachusetts, Rhode Island, Vermont, New Hampshire
Manley Khaleel	Chief, Primary Care	212-264-2549	New York	New York, New Jersey, Puerto Rico, Virgin Islands
Scott Otterbein	Regional Program Consultant	215-861-4414	Philadelphia	Pennsylvania, Delaware, Virginia, West Virginia, Maryland, District of Columbia
Stephen Dorage	Public Health Advisor	404-562-4127	Atlanta	Georgia, North Carolina, Alabama, Florida, Kentucky, Mississippi, South Carolina, Tennessee
Stephen A. Laslo	Regional Program Consultant	312-353-1254	Chicago	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Mathew Henk	Regional Program Consultant	816-426-5296 Ex. 239	Kansas City	Iowa, Kansas, Missouri, Nebraska
Jay McGath	Associate Field Director for Primary Care	214-767-4533	Dallas	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Nicholas Zucconi	Public Health Advisor	303-844-3203	Denver	Colorado, Minnesota, North Dakota, Utah, South Dakota, Wyoming
John Bruce	Public Health Advisor	415-437-8113	San Francisco	Arizona, California, Hawaii, Nevada, Guam, American Samoa, Freely Associated States of the Pacific, and the Commonwealth Northern Mariana Islands
Beryl Cochran	Regional Program Consultant	206-615-2490	Seattle	Arkansas, Idaho, Oregon, Washington

Timeline for Submission, Review, and Award:

March 7-16, 2000: Pre-Application Workshops conducted in the following locations:

Boston, MA	March 7, 2000
Atlanta, GA	March 8, 2000
Chicago, IL	March 9, 2000
Dallas, TX	March 14, 2000
Los Angeles, CA	March 15, 2000
Seattle, WA	March 16, 2000

June 1, 2000: Applications due

July 3-17, 2000: Applications reviewed

August 2000: Site visits to selected applicants

September 2000: Grant awards announced

CONTACT FOR ADDITIONAL INFORMATION

For further information regarding the Community Access Program, contact the program office:

Community Access Program Office
Health Resources and Services Administration
Parklawn Building, Suite 9A-30
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0536
Fax: (301) 443-0248